Washington Apple Health (Medicaid)

Maternity Support Services and Infant Case Management Billing Guide

October 1, 2017

About this guide*

This publication takes effect October 1, 2017, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

| Subject	Change	Reason for Change
Program webpage	Removed the reference to The First Steps Resource Guide and replaced it with a reference to the First Steps Maternity Support Services and Infant Case Management Provider webpage.	The guide no longer exists. Information has been moved to the new webpage.
How do I resolve issues with gender indicators when billing for transgender clients?	Added, "For a transgender client, providers must include a secondary diagnosis on the claim indicating that the client is transgender. Information on agency billing practices for transgender clients can be found in the Physician-Related Professional Services Billing Guide."	Clarification

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*This publication is a billing instruction.

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts webpage.

To access provider documents, go to the agency's provider billing guides and fee schedules webpage.

Where can I download agency forms?

To download an agency provider form, go to HCA's Billers and providers webpage, select Forms & publications. Type the HCA form number into the **Search box** as shown below (Example: 13-835).
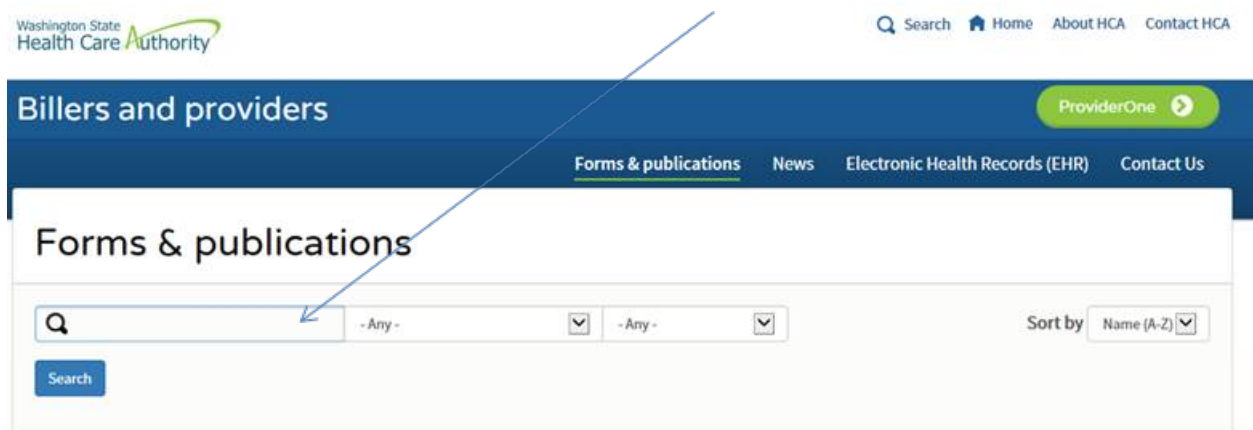
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Resources Available

Topic	Resource
Becoming a provider or submitting a change of address or ownership	HCA First Steps Program Manager 360-725-1293 Email: FirstSteps@hca.wa.gov
Obtaining prior authorization, limitation extension, or exception to rule	Fax all documents along with requests 1-866-668-1214
Policy or program oversight for Maternity Support Services	HCA First Steps Program Manager 360-725-1293 Fax: 360-725-1152 Email: FirstSteps@hca.wa.gov
Policy or program oversight for Infant Case Management	HCA First Steps Program Manager 360-725-1293 Email: FirstSteps@hca.wa.gov
General information, provider directory	View the First Steps webpage
Additional Medicaid resources	See the agency's ProviderOne Resources webpage.
Definitions	Refer to WAC 182-533-0315 and Chapter 182-500 WAC
Department of Health (DOH) credentialing requirements	Professional Credentialing Requirements
Health Benefit Exchange	wahealthplanfinder.org
Women, Infants, and Children (WIC) Nutrition program	WIC website and the Department of Health WIC webpage
Agency Billing Guides and other publications	See the agency's provider billing guides and fee schedules webpage.

Program Overview

What is First Steps?
(See WAC 182-533-0300)

Under the Maternity Care Access Act (RCW 74.09.800), the Medicaid agency established First Steps to provide access to services for eligible clients and their infants. Maternity Support Services (MSS) and Infant Case Management (ICM) are two components of the First Steps program. Services include:

- **Medical Services**, including:

  - ✓ Full medical coverage (see WAC 182-505-0115)

  - ✓ Prenatal care

  - ✓ Delivery

  - ✓ Post-pregnancy follow-up

  - ✓ One year of family planning services post-pregnancy for eligible clients

  - ✓ One year of full medical care for newborns (see WAC 182-505-0210)

- **Enhanced Services**, including**:**

  - ✓ MSS

  - ✓ ICM

  - ✓ Childbirth Education (CBE)

- **Alcohol and drug assessment and treatment services**

- **Other (ancillary) services,** including but not limited to expedited medical eligibility determination

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current [ProviderOne Billing and Resource Guide](#).

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's [Program Benefit Packages and Scope of Services](#) webpage.

> **Note:** Patients who wish to apply for Washington Apple Health can do so in one of the following ways:
>
> 1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org
> 2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
> 3. By mailing the application to:
>   Washington Healthplanfinder
>   PO Box 946
>   Olympia, WA 98507
>
> In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

What are Maternity Support Services and Infant Case Management?

Maternity Support Services (MSS) delivers enhanced preventive health and education services and brief interventions to eligible pregnant clients. Services are provided as early in a pregnancy as possible, based on the client's individual risks and needs.

Infant Case Management (ICM) improves the welfare of infants by providing their parents with information and assistance for necessary medical, social, educational, and other services through the infant's first year.

Goals of MSS/ICM include:

- Increasing:

    ✓ Early access and ongoing use of prenatal and newborn care

    ✓ Initiation and duration of breastfeeding

- Decreasing:

    ✓ Maternal morbidity and mortality

    ✓ Low birth-weight babies

    ✓ Premature births

    ✓ Infant morbidity and mortality rates

    ✓ Health disparities

    ✓ The number of unintended pregnancies

    ✓ The number of repeat pregnancies within two years of delivery

    ✓ Tobacco and nicotine use during pregnancy and pediatric exposure to second-hand smoke

Are managed-care organization clients eligible?

(See [WAC 182-538-060](#), [182-538-095](#), and [182-538-063](#))

Yes. Clients enrolled in agency-contracted managed care plans are eligible for MSS/ICM outside of their plan. The agency reimburses for MSS/ICM through its fee-for-service system and the providers bill the agency directly. To verify eligibility when the client is enrolled in a Medicaid agency-contracted managed care plan, view the managed care enrollment on the client benefit inquiry screen of ProviderOne.

Maternity Support Services

(See WAC 182-533-0310)

Purpose

The purpose of Maternity Support Services (MSS) is to:

- Improve and promote healthy birth outcomes. Services are delivered by an MSS interdisciplinary team to eligible pregnant and post-pregnant clients and their infants.

- Help clients to access:

    - ✓ Prenatal care as early in pregnancy as possible

    - ✓ Health care for eligible infants

Who is eligible for MSS?
(See WAC 182-533-0320)

To be eligible for MSS, a client must be:

- Pregnant or within 60 days postpartum (see "Maternity Cycle" definition in WAC 182-533-0315)

- Covered under a categorically needy (CN), medically needy (MN), alternative benefit plan (ABP), or state-funded medical program with Washington Apple Health

If the client is pregnant, check ProviderOne to determine if the client is currently covered under a Benefit Package. If not, the client may submit an application for full coverage. See the note in How can I verify a patient's eligibility?

For further information on verifying a client's eligibility, see the agency's ProviderOne Billing and Resource Guide. See the agency's Program Benefit Packages and Scope of Services webpage for a current listing of Benefit Packages.

Clients who do not agree with an eligibility decision by the agency have a right to an administrative hearing under Chapter 182-526 WAC.

Who is eligible to provide MSS?
(See WAC 182-533-0325)

MSS providers may include community clinics, federally qualified health centers (FQHCs), local health departments, hospitals, nonprofit organizations, and private clinics.

General requirements

MSS may be provided only by a provider who is currently enrolled and approved as an eligible provider with the agency.

The approved provider must also:

- Meet the requirements in Chapter 182-502 WAC and WAC 182-533-0325.

- Comply with Section 1902(a)(23) of the Social Security Act regarding the client's freedom to choose a provider. By law, all clients are free to choose any approved MSS provider, regardless of where they receive prenatal, post- pregnancy, or pediatric medical care. Clients cannot be limited to MSS providers in a given county or clinic, even if the client receives all other agency-covered services through that county or clinic.

- Comply with Section 1915(g)(1) of the Social Security Act regarding the client's voluntary receipt of services.

- Inform the eligible client of the *option* to receive MSS and *must not force* the client to receive MSS for which the client might be eligible.

- Ensure that professional staff providing MSS:

  - ✓ Meet staff qualifications

  - ✓ Complete an orientation to ensure the overall quality and continuity of client care

  - ✓ Follow the requirements under Chapter 182-533 WAC and this guide

- Screen each client for risk factors using the *MSS Prenatal Screening Tool* (HCA 13-874) form, and the *MSS Post-Pregnancy Screening Tool* (HCA 13-873) form. See Where can I download agency forms? If using electronic health records (EHR), the screening tool language must match what is on these forms. If the system is limited and unable to use exact language, agency approval is required; contact the First Steps Program Manager to obtain agency approval.

- Refer a client who may need a substance use disorder assessment to a provider who is contracted with the Division of Behavioral Health and Recovery (DBHR) through the Department of Social and Health Services (DSHS).

> **Note:** See DBHR Substance Use Treatment Services for information on treatment services and resources, including the Directory of Certified Chemical Dependency Services.

- Screen clients for ICM eligibility and document screening results in the client's chart.

- Conduct case conferences as described in this guide.

- Develop and implement an individualized care plan for each client.

- Initiate and participate in care coordination activities throughout the maternity cycle, with at least the MSS interdisciplinary team members, the client's prenatal care provider, and the Women, Infants, and Children (WIC) Nutrition office.

- Comply with documentation requirements.

- Maintain and make available to the agency upon request: clinical supervision plans, consultation plans, staff training plans, current and historical personnel rosters, and clients' charts and records covering the last 6 years. (See WAC 182-502-0020.)

- Create and maintain a system to track units used in service delivery. (See First Steps Maternity Support Services and Infant Case Management Provider webpage)

- Deliver MSS covered services as described in WAC 182-533-0330.

- Appoint a designated person (usually a First Steps Coordinator) to periodically view the First Steps Maternity Support Services and Infant Case Management Provider webpage for updates and information regarding the program.

- Obtain approval from the First Steps Program Manager of all MSS outreach-related materials, including websites and publications, prior to making the materials available to clients. Request for approval must be submitted via email or fax. The First Steps Program Manager will review the submitted outreach-related materials to ensure they provide accurate information regarding the services a client may receive through MSS and will send a determination by email. The provider must keep the approval email and the out-reach related materials reviewed in the provider's files.

> **Note:** MSS providers are mandatory reporters. If you are concerned that child abuse or neglect has occurred or is occurring, you must notify CPS by calling 1-800-363-4276.

Locations where services may be delivered

The provider and client together determine the most appropriate place for services to be delivered.

The agency pays for an MSS visit when the services are provided in any of the following places:

- The provider's office or clinic

- The client's residence (not allowed for group services)

- The hospital

- An alternate site other than the client's residence. (The reason for using an alternate site for visitation instead of the home must be documented in the client's record.)

MSS subcontractors

An individual or service organization that has a written contract with a qualified MSS provider also may provide MSS and Infant Case Management (ICM) services to eligible clients. Providers must do all of the following:

- Keep a copy of the written subcontractor agreement on file. (See staff-specific content in documentation requirements)

- Ensure that an individual providing MSS/ICM services meets the minimum regulatory and educational qualifications required of an MSS/ICM provider

- Ensure that the subcontractor satisfies the requirements of Chapter 182-532 WAC and these billing instructions

- Maintain professional, financial, and administrative responsibility for the subcontractor

- Bill for services using the provider's billing NPI and MSS/ICM taxonomy. (See covered services.)

- Reimburse the subcontractor for MSS/ICM services provided under the written agreement

What are the staff requirements for MSS?

To ensure the overall quality and continuity of client care, each provider must fulfill orientation and staff requirements and provide required program services. (See WAC 182-533-0327)

Orientation requirements

Providers must ensure that their staff follow the requirements under Chapter 182-533 WAC and this provider guide. During orientation, professional staff must read:

- Chapter 182-533 WAC

- Maternity Support Services and Incase Case Management Billing Guide (this guide)

- First Steps Maternity Support Services and Infant Case Management Provider webpage

- Prenatal and Post-Pregnancy Screening Guides (Risk Factor support documents)

- Prenatal and Post-Pregnancy Risk Factor Matrix (Risk Factor definitions and outcome measures)

- Prenatal and Post-Pregnancy Clarifications (Clarification notes)

The date each employee completed the orientation must be documented and made available to the agency upon request.

The MSS interdisciplinary team

The provider's qualified staff must participate in an MSS interdisciplinary team consisting of at least a community health nurse, a certified registered dietitian, a behavioral health specialist, and, at the discretion of the provider, a community health representative/worker.

- The interdisciplinary team must work together to address risk factors identified in a client's care plan.

- Each qualified staff member must act within their area of expertise and must address the client's needs identified during the maternity cycle.

- Team members must participate in a case conference at least once prenatally for clients who are entering MSS during pregnancy and are eligible for the maximum level of service. Using clinical judgment and the client's risk factors, the provider may decide which interdisciplinary team members to include in case conferencing.

Staff qualifications

MSS providers must use qualified professionals as specified in the table below. For more information about the Department of Health's (DOH's) qualifications for licensed and credentialed staff, including continuing education, see the online DOH Health Care Professional Credentialing Requirements website.

Type of Professional Staff	Qualifications and Other Requirements
Behavioral Health Specialists	Currently credentialed or licensed in the State of Washington by the DOH Chapters 246-809, 246-810, and 246-924 WAC as one of the following: • Licensed mental health counselor • Licensed independent clinical social worker • Licensed social worker • Licensed marriage and family therapist • Licensed psychologist • Associate mental health counselor • Associate independent clinical social worker • Associate social worker • Associate marriage and family therapist • Certified counselor • Certified chemical dependency professional
Certified Dietitians	Currently registered with the Commission on Dietetic Registration and certified by the DOH under Chapter 246-822 WAC
Community Health Nurses	Currently licensed as registered nurses in the State of Washington by the DOH under Chapter 246-840 WAC
Community Health Representatives/Workers	• Have a high school diploma or equivalent • Have a minimum of one year of health care or social services experience • Complete a training plan by their provider • Carry out all activities under the direction and supervision of a professional member or supervisor of the MSS interdisciplinary team

Note: The Medicaid agency will not pay for MSS provided by student interns. The agency considers claims for services provided by nonqualified staff as erroneous claims and will recover any resulting overpayment.

Requirements for Tribes, Indian Health Programs, and certain counties

All Tribes, Indian Health Programs, and any MSS provider within a county with fewer than 55 Medicaid births per year to county residents must meet all MSS program requirements in this guide, and are required to have at least one of the following interdisciplinary team members:

- A behavioral health specialist

- A registered dietitian

- A community health nurse

All of these clinical staff must meet the staff qualifications detailed within this guide, and must complete the orientation requirements, whether delivering direct services or supervising MSS staff. When a client's needs are outside the scope of practice of the clinician, appropriate referrals and consultations must be attempted and documented.

What are the MSS program components?
(See WAC 182-533-0325 and 182-533-0330)

Program components for MSS include screening, assessments, case conferences, care plans, case management, and care coordination. These services must be documented in the client's records.

Screening

Screening is required for each client. The screening process is a method for systematically identifying and documenting risk factors and client need.

Once a risk factor or need is identified, a behavioral health specialist, community health nurse, or registered dietitian may need to assess the client further to determine the client's level of service. Screening is not an in-depth assessment for risk factors.

There are two screening guides. Both the *MSS Prenatal Screening Guide* and the *MSS Post - Pregnancy Screening Guide* are reference documents where sample screening questions can be found. Both screening guides are located on the First Steps Maternity Support Services and Infant Case Management Provider webpage.

Assessment

An assessment or evaluation beyond screening may be necessary. An assessment should expand beyond screening in the content area being evaluated. All types of assessments must be documented in the client's chart by date.

Case conference

Case conferences are used by members of the MSS interdisciplinary team to communicate and consult with each other and, when possible, with other health care providers, social services providers, and the client. The purpose of a case conference is to optimize client's care by addressing risk factors that may lead to poor birth outcomes for the client. Case conferences may be done in person, by phone, or through secure technological applications.

At least one prenatal MSS interdisciplinary team case conference is required for clients who are entering MSS during pregnancy and are eligible for the maximum level of service. The provider may decide, based on the client's risk factors, which interdisciplinary team members to include in case conferencing.

Care plan

Based on the results of an MSS screening and assessment, the interdisciplinary team must develop and implement an individualized care plan for each client. The care plan contains information specific to the client's identified risk factors and is used to prioritize those risk factors and guide interventions.
An effective care plan includes:

- Assessment
- Planning
- Intervention
- Rationale
- Evaluation

The care plan should be updated throughout the maternity cycle and must reflect an overview of the client's identified risk factors and the anticipated interventions. For risk factors that are identified and not addressed, an explanation of why the risk factors were not addressed must be included in the chart.

The community health nurse, behavioral health specialist, or registered dietitian must be involved in developing the care plan for clients eligible for expanded and maximum service levels. A list of the team members involved in developing the care plan must be kept in the client's file.

Case management

Case management is a collaborative process of assessment, care planning, facilitation, care coordination, evaluation, and advocacy for options and services that meet the health and social service needs of infants and pregnant clients.

A key aspect of case management is making referrals for pregnant clients to:

- Medical care

- Women, Infants, and Children (WIC) Nutrition program

- Childbirth Education (CBE) services

- Within Reach/ParentHelp123

- Quitline for tobacco and nicotine use

- Family planning providers

- Treatment for chemical dependency, mental health problems, or domestic violence, as needed

- Other services and community resources, as needed

Care coordination

Providers must initiate and participate in care coordination throughout the maternity cycle to ensure that care is delivered in a logical, connected, and timely manner.

Care coordination must be documented in the client's file and may include any of the following:

- Face-to-face meetings

- Phone calls

- Secure emails

At a minimum, care coordination must occur within the MSS interdisciplinary team, with the client's prenatal care provider, and the WIC office. Communication with other community resources working with the client may be necessary to provide appropriate needed care. In addition, providers must coordinate with other MSS providers to reduce duplication and to ensure continuity of care.

Before seeing a client for the first time, providers must ask if the client is being seen by another MSS provider for the current pregnancy to determine if the client's MSS benefit limit has been partially used or met. In addition, providers should contact HCA to find out if MSS claims have been paid for a client. Instructions for this process can be found under *Key Step 6* in the ProviderOne Billing and Resource Guide.

If a client received MSS from another provider, the client may not receive services from a new MSS provider unless the client voluntarily chooses to switch providers. For clients who choose to receive MSS from a new provider, the client must indicate the client's choice in writing and it must be signed and dated. This information must be:
- Given to the MSS provider the client received services from; and
- Documented in the client's file.

When a client chooses to receive services from a new provider, the previous provider must transfer the client's entire chart, including screening tools, care plans, and remaining units. This will ensure continuity of care, reduce service duplication, and inform the new provider of the number of remaining MSS units.

New provider limitation extension requests will not be approved for additional units without the client's previous MSS chart.

Group services

(See WAC 182-533-0345)

Providers may offer group services to clients who are eligible for MSS. The group sessions must be voluntary and provide preventive health and education services, as well as brief interventions specific to the client's identified risk factors. Risk factors may include issues related to:

- Alcohol and substance abuse or addiction
- Developmental disability
- Intimate partner violence
- Medical care
- Mental health
- Nicotine use
- Nutrition

Group activities are expected to address specific identified risk factors. The goal is to improve the outcome of pregnancy, birth, and parenting. Session content may include information about self-care and coping strategies, nutrition and diabetic education and awareness, family violence, substance use and abuse, and depression and anxiety.

The group must have a minimum of 3 and maximum of 12 MSS clients. Each group session must be provided for a minimum of 1 hour and a client is eligible for 1 group activity per day. Group services may not be provided by a community health representative/worker and are not allowed in a client's residence.

Each group session must be documented for each client. The client's chart must include the group facilitator's name, the topics and basic health messages discussed, and the number of attendees. If a provider chooses to use a presenter who specializes in the clients' risk factors, the presenter's name and contact information and the name of the interdisciplinary team member who was in attendance must also be added to each client's chart.

The provider must maintain a list of all attendees for each session. Each list must be kept in the provider's file and made available to the agency as required in WAC 182-502-0020.

Note: Providers are required to manage the available units of service to meet the client's needs throughout the maternity cycle. See levels of service for details about minimum and maximum units of service available for clients.

What documentation is required for MSS?
(See WACs 182-502-0020 and 182-533-0328)

All providers must satisfy the documentation requirements in WAC 182-502-0020 and this guide, regardless of whether the provider creates the documents by hand or electronically. All documentation must be maintained for at least 6 years, must be submitted to the agency upon request, and made available during on-site visits and chart reviews.

Charting overview

Each provider must maintain a client record for each client that concisely states the services provided and shows how those services support the number of units billed. The client record must also clearly demonstrate the risk-factor progression from identification to final client outcome.

Client-specific records

Each client record must be stored in a single file that contains:

- Required MSS Prenatal and Post-Pregnancy screening tools (form 13-874, 13-873, or provider-specific tool approved by the First Steps Program Manager).

- Assessment records

- Case conference records, which must include dates and the team members involved, and whether or not the care plan was updated based on the case conferences

- Care coordination records

- Care plan records. The care plan must reflect an overview of the client's identified risk factors and anticipated interventions. For risk factors that are identified and not addressed, an explanation of why the risk factors were not addressed must be included in the chart. The care plan must identify all of the people who participated in the plan.

- Client data, including:

  - ✓ The client's name

  - ✓ The date of birth

  - ✓ Contact information (address and phone numbers)

  - ✓ Race (and if applicable, ethnicity or tribal affiliation)

- ✓ The client's primary spoken language

- ✓ The client's ProviderOne Client ID and effective date

- Client outcome and discharge data. Providers are required to determine and record all of the following client data:

    - ✓ The date and reason for the discharge from MSS

    - ✓ Outcomes related to any identified MSS targeted risk factors

    - ✓ Weeks of gestation when prenatal care began

    - ✓ The date family planning was discussed and whether a birth control method was initiated

    - ✓ Infant weight and gestational weeks at time of birth

    - ✓ Client-initiated breastfeeding, if applicable:

        - ➢ Was it exclusive?

        - ➢ Was the client still breastfeeding at discharge?

    - ✓ The date the client was screened for depression and results of screening, if applicable

    - ✓ Results of an ICM screening, if completed during the MSS eligibility period, with ICM services documented as:

        - ➢ Provided

        - ➢ Deferred, because the client or family is receiving case management services as part of another program

        - ➢ Declined by the client

    - ✓ Final client outcomes that are recorded in a one summary report

- Consent to care document signed and dated by the client indicating whether the client consented or refused care.

- Contact log. Client records must have a chronology of contacts made with or regarding the client. Contact may be in person, in writing, or by phone. The contact log must include the following:

    - ✓ The date of the contact

- ✓ A brief description of the nature of the contact

- ✓ The name of the person making the contact

- ✓ The name of the person or agency who was contacted

- A *Freedom of choice* document provided for each client to read, sign, and date. The declaration must inform the client:

  - ✓ That the client is not required to participate in MSS

  - ✓ That the client is free to choose any MSS provider to receive MSS regardless of where the client lives or where the client receives health care and WIC services.

  - ✓ Of all MSS providers in the county, and the surrounding area for those counties with less than two MSS providers, where the client resides

- A *Release of Information* form. MSS is considered health care services and is covered under HIPAA regulations. Each provider is responsible for developing their own *Release of Information* form, which must comply with RCW 70.02.030 and must be signed by the client.

- A written statement signed and dated by the client indicating the client's choice to receive services from a new provider, if applicable

- Visit records and notes for each MSS visit that include:

  - ✓ The date of the visit

  - ✓ The time the visit started and ended

  - ✓ The location of the visit, such as a home, office, alternate site

  - ✓ Any intervention provided

  - ✓ Client progress related to risk factors in the care plan and addressed during the visit

  - ✓ The reason for not addressing a prioritized risk factor at visit

  - ✓ Any follow-up required from the previous visit

  - ✓ Next steps

  - ✓ The signature of the person providing services

Staff-specific records

Providers also must keep the following documentation for all professional staff and subcontractors:

- Training and supervision records for community health representatives/workers

- Continued education verification

- Current credentials for professional staff

- Proof professional staff completed an orientation

- Subcontracting documents, as specified under WAC 182-533-0325(3)

- A signature log, which is a typed list that verifies a provider's identity by associating each provider's signature with their name, handwritten initials, and title

What services are covered under MSS?
(See WAC 182-533-0330 and 182-533-0345)

The agency covers MSS provided by an MSS interdisciplinary team member. Covered services include:

- In-person screening of risk factors related to pregnancy and birth outcomes

- Brief assessment when indicated

- Education related to improving outcomes of pregnancy and parenting

- Brief counseling

- Interventions for risk factors identified in the care plan

- Basic health messages

- Case management

- Care coordination

- Infant case management (ICM) screening

The agency pays for these services on a fee-for-service basis if MSS is:

- Provided to a client who meets the eligibility requirements in WAC 182-533-0320

- Provided to a client in a face-to-face encounter

- Provided by a provider who meets the MSS provider requirements

- Documented correctly in the client's chart (see MSS documentation requirements)

- Billed using the eligible client's ProviderOne Client ID

- Billed using the correct procedure codes and modifier(s) identified in this guide. (See the MSS coverage table.)

- Billed using the provider's billing NPI and taxonomy code 171M00000X

The agency pays the provider for furnishing MSS to eligible clients, not the provider's subcontractor, for furnishing MSS. (See more about subcontracting.)

> **Note:** Travel expenses, documentation time, phone calls, and mileage are built into the reimbursement rate for MSS. If the client becomes pregnant within 12 months from the end of her previous pregnancy, enter the new due date in *Claim Note* section of the professional claim for new services.

Levels of service
(**WAC 182-533-0345**)

The agency may redetermine the maximum number of units allowed per client when directed by the legislature to achieve targeted expenditure levels for payment in any specific biennium. (The maximum number of MSS units allowed per client is published in this guide.)

- Providers must bill for services delivered fee-for-service:

  ✓ In 15-minute increments for individual services, or

  ✓ For 1 hour for group services.

- If two or more of the MSS provider's staff meet with a client at the same time, only one of them can bill for a given unit spent with the client. For example:

  ✓ Individual services: If a registered nurse and a registered dietitian visit a client together for 45 minutes, a maximum of three units is billable for this visit.

  ✓ Group services: If a registered nurse and a behavioral health specialist provide a group session together, a maximum of one unit is billable for each eligible client.

- No more than six units per client may be billed for one date of service.

- Clients are eligible for only one MSS group service per day.

- If the client's level of service increases, the client is eligible for more units. For example, the client may move from basic to expanded services if additional qualifying risk factors are identified.

- Clients enrolled in MSS prenatally must be screened during post-pregnancy to assess whether an increase in level of service is needed due to new risk factors.

- If all available units are used during the prenatal period, staff must document the following:

  ✓ The client's circumstances and the reason that all units were used prenatally

  ✓ Actions taken to link the client to other related services (such as medical care and WIC) that address post-pregnancy needs

Level of service and allowable units during the entire maternity cycle		Required Services
Client Enrolled in MSS During Prenatal Period	Basic = 7 units	Screening, Care Coordination, Case Management, Basic Health Messages, and Other Messages based upon client need
	Expanded = 14 units	Screening, Care Coordination, Case Management, Basic Health Messages, Clinical Assessment, and Interventions
	Maximum = 30 units	Screening, Care Coordination, Case Management, Basic Health Messages, Clinical Assessment, Interventions, and Case Conference
Level of service and allowable units during the post-pregnancy eligibility period		Required Services
Client Enrolled in MSS Post-Pregnancy Period Only (client did not receive any MSS during the prenatal period)	Basic = 4 units	Screening, Care Coordination, Case Management Basic Health Messages, and Other Messages based upon client need
	Expanded = 6 units	Screening, Care Coordination, Case Management, Basic Health Messages Clinical Assessment, and Interventions
	Maximum = 9 units	Screening, Care Coordination, Case Management, Basic Health Messages, Clinical Assessment, Interventions, and Case Conference.

Limitation extension requests

The provider may request a limitation extension to exceed the number of MSS units of service allowed under WAC 182-501-0169.

- A limitation extension request must be preauthorized.
- Limitation extension requests:

  ✓ Must be submitted with:

  ➢ The *General Information for Authorization* (HCA 13-835) form, as the first page (DO NOT use a coversheet), see Where can I download agency forms?

  ➢ The *Limitation Extension Request* (Maternity Support Services and/or Infant Case Management), (HCA 13-884) form, as the second page

  ➢ The complete MSS chart, which includes the care plan and screening tools

  ✓ Must be completed according to the directions on the forms

  ✓ Must be faxed to 1-866-668-1214.

> **Note:** Federally Qualified Health Centers (FQHCs) must follow billing guidelines found in the Medicaid agency's Federally Qualified Health Center (FQHC) Medicaid Provider Guide.

Telemedicine

Telemedicine is when a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered services that are within the provider's scope of practice to a client at a site other than the site where the provider is located.

MSS clients may be eligible for telemedicine. Information on agency rules and how to bill for telemedicine can be found in the Physician-Related Services/Healthcare Professional Service Provider Guide.

What services are not covered?

(See WAC 182-533-0340)

The agency covers only those services listed in WAC 182-533-0330. Requests for noncovered services are evaluated under WAC 182-501-0160.

MSS Coverage Table

Procedure Code	Diagnosis Code	Modifiers (bill in order as shown below)	Short Description	Comments
Maternity Support Services				
T1002		HD	RN services, up to 15 minutes	1 unit = 15 minutes during an MSS community health nursing visit
T1002		HD TF	RN services, up to 15 minutes	1 unit = 15 minutes during an MSS community health nursing visit for clients screening in with risk factors at expanded level
T1002		HD TG	RN services, up to 15 minutes	1 unit = 15 minutes during an MSS community health nursing visit for clients screening in with risk factors at maximum level (high risk)
S9470	See the agency's Approved Diagnosis Codes by Program webpage	HD	Nutritional counseling, dietitian visit	1 unit = 15 minutes during an MSS dietitian visit
S9470		HD TF	Nutritional counseling, dietitian visit	1 unit = 15 minutes during a MSS dietitian visit for clients screening in with risk factors at expanded level
S9470		HD TG	Nutritional counseling, dietitian visit	1 unit = 15 minutes during a MSS dietitian visit for clients screening in with risk factors at maximum level (high risk)
96152		HD	Behavioral health specialist	1 unit = 15 minutes during an MSS behavioral health visit
96152		HD TF	Behavioral health specialist	1 unit = 15 minutes during an MSS behavioral health visit for clients screening in with risk factors at expanded level

Procedure Code	Diagnosis Code	Modifiers (bill in order as shown below)	Short Description	Comments
Maternity Support Services				
96152	See the agency's [Approved Diagnosis Codes by Program] webpage	HD TG	Behavioral health specialist	1 unit = 15 minutes during an MSS behavioral health visit for clients screening in with risk factors at maximum level (high risk)
T1027		HD	Family training and counseling for child development (community health representative/ worker)	1 unit = 15 minutes during an MSS community health representative /worker visit
T1027		HD TF	Family training and counseling for child development (community health representative/ worker)	1 unit = 15 minutes during an MSS community health representative /worker visit for clients screening in with risk factors at expanded level
T1027		HD TG	Family training and counseling for child development (community health representative/ worker)	1 unit = 15 minutes during an MSS community health representative /worker visit for clients screening in with risk factors at maximum level (high risk)
S9446		HD	Patient education, group	1 unit = minimum 60 minutes during an MSS group session
S9446		HD TF	Patient education, group	1 unit = minimum 60 minutes during an MSS group session for clients screening in with risk factors at expanded level

Procedure Code	Diagnosis Code	Modifiers (bill in order as shown below)	Short Description	Comments
Maternity Support Services				
S9446	See the agency's Approved Diagnosis Codes by Program webpage	HD TG	Patient education, group	1 unit = minimum 60 minutes during an MSS group session for clients screening in with risk factors at maximum level

Note: To receive reimbursement, Tribal programs must use the procedure code and modifier(s) above, and one of these *additional* modifiers based on the client's demographic information.

Client demographic	Additional Modifier
American Indian or Alaska Native	UA
Nonnative person	SE

Infant Case Management

(See WAC 182-533-0360)

Purpose

The purpose of Infant Case Management (ICM) is to improve the welfare of infants by providing their parents with information and assistance to access medical, social, educational, and other services. Families that meet criteria for ICM will be offered services focused on referrals and linkage to community resources and client advocacy. Clients who did not receive Maternity Support Services (MSS) may be eligible for ICM services.

For the purposes of ICM, a parent is any person who resides with an infant, provides the infant's day-to-day care, and is one or more of the following:

- The infant's natural or adoptive parent

- A person other than a foster parent who has been granted legal custody of the infant

- A person who is legally obligated to support the infant

Who is eligible for ICM?

(See WAC 182-533-0370)

To be eligible for ICM, the infant must:

- Be covered under categorically needy (CN), medically needy (MN), alternative benefit plan (ABP), or state-funded medical programs with Washington Apple Health

- Meet the age requirement for ICM, which is the day after the maternity cycle ends, through the last day of the month of the infant's first birthday

- Reside with at least one parent who needs assistance accessing medical, social, educational, or other services to meet the infant's basic health and safety needs

- Not be receiving any case management services funded through Title XIX Medicaid that duplicate ICM services

For instructions on how to verify a client's eligibility, see the agency's *ProviderOne Billing and Resource Guide*. See the agency's Program Benefit Packages and Scope of Services webpage for a current listing of benefit packages. Clients who disagree with an eligibility decision by the agency have a right to a fair hearing under Chapter 182-526 WAC.

Eligibility when the infant's mother becomes pregnant during the ICM eligibility period

If the infant's mother becomes pregnant during the ICM eligibility period and the mother is eligible for MSS, the infant and the infant's mother are no longer eligible to receive ICM services. The MSS eligibility period begins when the mother learns of the pregnancy. Maternity Support Services for the new pregnancy are billed using MSS procedure codes.

Eligibility when the infant is placed outside the home

If the infant does not live with a parent, the infant is not eligible for ICM services. If the infant is returned to a parent during the ICM eligibility period, the provider may determine eligibility for ICM.

Examples

- A child is placed outside the home in foster care. Children's Administration (CA) provides Targeted Case Management (TCM) and is the legal custodian of the child. This child is no longer eligible for ICM.

- A child has an open Child Protective Services (CPS) case and is still in the parents' home. ICM could be delivered to the family in the home without the concern of duplicate billing.

- Grandparents have legal custody of the infant. The infant may be eligible for ICM, provided that the infant meets the eligibility criteria to receive services.

Who is eligible to provide ICM?
(See WAC 182-533-0375)

General requirements

ICM services may be provided only by a qualified infant case manager who is employed by a provider meeting the requirements in WAC 182-533-0325.

Approved providers must:

- Meet the requirements in Chapter 182-502 WAC and WAC 182-533-0325.

- Comply with Section 1902(a)(23) of the Social Security Act, which requires that all clients must be free to choose any approved MSS/ICM provider regardless of where they receive prenatal, post-pregnancy, or pediatric medical care. Clients cannot be limited to MSS/ICM providers in a given county or clinic, even if the client receives all other

agency-covered services through that county or clinic.

- Comply with Section 1915(g)(1) of the Social Security Act, which requires that an approved provider must inform the eligible client of the option to receive MSS/ICM and must not force the client to receive MSS/ICM services for which the client or the client's infant might be eligible.

- Screen clients for ICM eligibility and document screening results in the client's chart.

- Employ staff who meet staff qualifications and complete a required orientation to ensure the overall quality and continuity of client care.

- Comply with all documentation requirements.

- Maintain clinical supervision plans, consultation plans, staff training plans, current and historical personnel rosters, and client charts and records. These documents must be made available to the agency upon request.

- Retain these records for at least 6 years. (See WAC 182-502-0020.)

- Create and maintain a system to track units of service delivered. (See First Steps.)

- Deliver ICM covered services as described in WAC 182-533-0380.

- Appoint a designated person (usually a First Steps Coordinator) to periodically review the First Steps Maternity Support Services and Infant Case Management Provider webpage for updates and information regarding the program.

  - Obtain approval from the First Steps Program Manager of all ICM outreach-related materials, including websites and publications, prior to making the materials available to clients. Request for approval must be submitted via email or fax. The First Steps Program Manager will review the submitted outreach-related materials to ensure they provide accurate information regarding the services a client may receive through MSS, and will send a determination by email. The provider must keep the approval email and outreach-related materials reviewed in the provider's files.

> **Note:** ICM providers are mandatory reporters. If you are concerned that child abuse or neglect has occurred, or is occurring, you must notify CPS by calling 1-800-363-4276.

Staff qualifications

ICM services must be provided by an infant case manager who is employed by an approved provider. The infant case manager must meet at least one of the following sets of qualifications.

Qualifications for an Infant Case Manager		
1. Be a current member of the MSS interdisciplinary team who qualifies as a behavioral health specialist, registered dietitian, or community health nurse.	and	Meet MSS staff requirements and WAC 182-533-0327.
2. Have a bachelor's or higher degree in a social service-related field, such as social work, behavioral sciences, psychology, child development, or mental health.	and	Have at least one year of full-time experience working in one or more of the following areas: • Community services • Social services • Public health services • Crisis intervention • Outreach and referral programs • Other related fields
3. Have an associate of arts degree or associate's degree in a social service-related field, such as social work, behavioral sciences, psychology, child development, or mental health.	and	Have at least two years of full-time experience working in one or more of the following areas: • Community services • Social services • Public health services • Crisis intervention • Outreach and referral programs • Other related fields And be supervised by a clinical staff person who meets the requirements under #1 or #2 in this table. Clinical supervision may include face-to-face meetings and/or chart reviews.

Note: The agency considers claims for services provided by nonqualified staff as erroneous claims and will recover any resulting overpayment.

Locations services may be delivered

The agency pays for an ICM visit when the services are provided in:

- The provider's office or clinic

- The infant's residence

- An alternate site that is not the client's residence. (The reason for using an alternate site for visitation instead of the home must be documented in the client's record.)

What are the ICM program components?
(See WAC 182-533-0380)

Program services for ICM include screening, assessment, care plans, case management, and care coordination. These services must be documented in the client's records.

Screening

Screening is required for each client. A member of the interdisciplinary team or an infant case manager must systematically identify and document the client's needs and risk factors to determine the appropriate level of service. Screening is not an in-depth assessment of risk factors.

Assessment

An assessment or evaluation beyond screening may be necessary. An assessment should expand beyond screening in the content area being evaluated. All types of assessments must be documented in the client's chart by date.

Care plan

Based on results of an ICM screening, the provider must develop and implement an individualized care plan for each client. The care plan contains information specific to the client's identified risk factors and is used to prioritize those risk factors and guide interventions.

An effective care plan includes:

- Assessment

- Planning

- Intervention

- Rationale

- Evaluation

The care plan should be updated as needed throughout the ICM eligibility period.

Case management

Case management is a collaborative process of assessment, facilitation, care planning, care coordination, evaluation, and advocacy for options and services that meet the health and social service needs of the infant and family.

A key aspect of case management is referrals for infants and families to:

- Medical care

- Women, Infants, and Children (WIC) Nutrition program

- Childbirth Education (CBE) services

- Within Reach/ParentHelp123

- Quitline for tobacco/nicotine use

- Family planning providers

- Treatment for chemical dependency, mental health problems, or domestic violence, as needed

- Other services and community resources

Care coordination

Care coordination is a comprehensive approach to achieving continuity of care for clients. This approach seeks to ensure that care is delivered in a logical, connected, and timely manner so that the medical and personal needs of the infant and family are met.

Care coordination must be documented in the client's file and may include any of the following:

- Face-to-face meetings

- Phone calls

- Secure emails

Providers must coordinate with other ICM providers. Providers must ask if the client is being seen by another ICM provider and determine if the client's ICM benefit limit has been partially used or met. In addition, providers should contact the agency to determine if a client has paid ICM claims. Instructions for this process can be found under *Key Step 6* in the ProviderOne Billing and Resource Guide. Communication with other community resources working with the family may also be necessary to provide the appropriate needed care.

When a client's parent chooses to receive services from a new provider, the previous provider must transfer the client's entire chart, including screening tools, care plans, and remaining units to the new ICM provider. This will ensure continuity of care, reduce service duplication, and inform the new provider of the number of remaining ICM units.

For clients' parents who choose to receive ICM from a new provider, the client's parent must indicate the new choice in writing and it must be signed and dated. This information must be:

- Given to the ICM provider the client was receiving services from, and
- Documented in the client's file.

New provider limitation extension requests will not be approved for additional units without the client's previous MSS chart.

> **Note:** Providers are required to manage the available units of service to meet the infant and family's needs throughout the ICM eligibility period. See levels of service for the range of service units available to clients.

What documentation is required for ICM?
(See WACs 182-502-0020 and 182-533-0378)

All providers must satisfy the documentation requirements in WAC 182-502-0020 and this guide, regardless of whether the provider creates the documents by hand or electronically. All documentation must be maintained for at least 6 years, submitted to the agency upon request, and made available during on-site visits and chart reviews.

Charting overview

Each provider must maintain a client record for each client that concisely states the services provided and shows how those services support the number of units billed. The client record must also clearly demonstrate the risk-factor progression from identification to final client outcome.

Client-specific records

The required record content for ICM clients includes:

- The *ICM Screening Tool* (HCA 13-658) form. See [Where can I download agency forms](#)? If using electronic health records (EHR), the screening tool language must match what is on the form. If the system is limited and unable to use exact language, agency approval is required; contact the [First Steps Program Manager](#) to obtain agency approval.

- All notes by the infant case manager, subcontractors, and consultants

- Assessment records

- Care coordination records, including all care coordination activities for the client

- Care plan records. The care plan must reflect an overview of the client's identified risk factors and anticipated interventions. For risk factors that are identified and not addressed, an explanation of why the risk factors were not addressed must be included in the chart. The care plan must identify all the people who participated in the plan.

- Consent to care document signed and dated by the client's [parent,](#) indicating whether the parent consented or refused care

- Contact log. Client records must have a chronology of contacts made with or regarding the client. The contact log must include the following:

  - ✓ The date of the contact

  - ✓ A brief description of the nature of the contact

  - ✓ The name of the person making the contact

  - ✓ The name of the person or agency who was contacted

- Legible and accurate demographic and contact information, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ The client's name

  - ✓ The date of birth

  - ✓ Contact information (address and phone numbers)

  - ✓ Race (and if applicable, ethnicity, and tribal affiliation)

- ✓ Primary language spoken

- ✓ The infant's ProviderOne Client ID number and effective date

- ✓ The infant's parent or guardian information

- A *Freedom of choice* document provided for each client's parent to read and sign. The declaration must inform the parent:

  - ✓ The client and parent are not required to participate in ICM.

  - ✓ The client and parent are free to choose any ICM approved agency to receive ICM regardless of where the client lives or receives health care and/or WIC services.

  - ✓ Of all ICM providers in the county where the infant resides and the surrounding areas for those counties with less than two ICM providers.

- A *Release of information form*. ICM services are considered health care services and are covered under HIPAA regulations. Each provider is responsible for developing their own *Release of information* form, which must comply with RCW 70.02.030 and must be signed by the client.

- A written statement signed and dated by the client's parent indicating the parent's choice to receive services from a new provider, if applicable.

- Client outcome and discharge data.

  Providers are required to determine and record all of the following client data:

  - ✓ The date and reason for the discharge from ICM

  - ✓ Final client outcomes that are recorded in a one summary report

  - ✓ Results of ICM screening with ICM services are documented as:

    - ➢ Provided

    - ➢ Deferred, because the client/family is receiving case management services as part of another program

    - ➢ Declined by the client's parent

- Visit records and notes for each ICM visit that include:

  - ✓ The date of the visit

  - ✓ The time the visit started and ended

✓ The location of the visit—home, office, alternate site

✓ Any interventions provided, such as referrals and linkages

✓ Client progress related to risk factors on the care plan and addressed during the visit

✓ The reason for not addressing a prioritized risk factor at visit

✓ Any follow-up required from the previous visit

✓ Next steps

✓ The signature of the person providing ICM services

Staff-specific records

Providers must keep the following documentation for all professional staff:

- Supervision records for infant case managers

- Continued education verification

- Current credentials for professional staff

- A signature log, which is a typed list that verifies a provider's identity by associating each provider's signature with their name, handwritten initials, and title

What services are covered under ICM?
(See WACs 182-533-0380 and 182-533-0386)

The agency covers eligible infants on a fee-for-service basis for case management under the ICM program, including:

- An initial in-person screening, which includes an assessment of risk factors and the development of an individualized care plan

- Case management services and care coordination

- Referring the infant and parents to other services or resources

- Advocacy for the infant and parents

- Follow-up contact with the parents to ensure the care plan continues to meet the needs of the infant and parents

The agency pays for these services when:

- Provided to a client who meets the eligibility requirements in WAC 182-533-0370

- Provided by a person who meets the ICM provider requirements listed in this guide

- Documented in a manner that satisfies the ICM documentation requirements

- Billed using:

  - ✓ The infant's ProviderOne Client ID

  - ✓ The correct procedure codes and modifiers identified in this provider guide

  - ✓ The provider's billing NPI and taxonomy code 171M00000X

Levels of service

The agency may redetermine the maximum number of units allowed per client when directed by the legislature to achieve targeted expenditure levels for payment in any specific biennium. The maximum number of ICM units allowed per client is published in this guide.

All infants and parents must be screened to determine if there is a need to help the family access medical, social, educational, or other services. The number of units an infant may receive is based on the amount of assistance the parent needs to address identified risks.

Providers screening infants and parents must use the ICM Screening Tool. If no risk factor is identified (in Column A of the form), the amount of services is limited to 2 units for the eligibility period, unless there is a change in circumstances. Units used to screen clients are included in the maximum allowed in each level.

All services must be delivered face-to-face with the infant present.

Lower level case management allows an infant up to 6 units of ICM services during the ICM eligibility period. This means that the parents are able to access services with minimal assistance from an infant case manager.

Higher level case management allows a client up to 20 units of service during the eligibility period. For higher level services, parents must demonstrate a greater need for assistance accessing services. The infant case manager may provide additional services based on a family's identified needs.

Examples of parents who need more assistance include those who:

- Miss scheduled appointments

- Request extra services due to circumstances that prevent access, such as suffering from depression

- Have little understanding of infant and child development, e.g., adolescent parents

- Have a premature infant who has complex medical needs

> **Note:** The units used screen during the ICM eligibility period must be deducted from the maximum number of units allowed for whatever level the infant or parent qualifies.

Number of units for levels of service

Providers must bill in units of service with one unit of service equaling 15 minutes, delivered face-to-face. Other considerations for billing ICM units are:

- No more than 2 units may be billed to complete the *ICM Screening Tool* (HCA 13-658) form. See Where can I download agency forms?

- Infants qualifying for lower level may receive a maximum of 6 units of service throughout the ICM eligibility period, as documented using the *ICM Screening Tool* (HCA 13-658) form.

- Infants qualifying for higher level may receive a maximum of 20 units of service throughout the ICM eligibility period as documented using the *ICM Screening Tool* (HCA 13-658) form.

- If the infant's circumstances cause a change to a higher level of service, the appropriate number of units may be added. Total units may not exceed 20.

- If the infant's circumstances cause a change to a lower level of service, the units of service available do not change. However, the client must demonstrate need for remaining units to be used.

Limitation extension requests

The provider may request authorization for a limitation extension to exceed the number of allowed ICM units of service under WAC 182-501-0169.

- A limitation extension request must be preauthorized.

- Limitation extension requests:

  ✓ Must be submitted with:

  ➢ The *General Information for Authorization* (HCA 13-835) form as the first page (DO NOT use a coversheet), see Where can I download agency forms?

  ➢ The *Limitation Extension Request* (Maternity Support Services and/or Infant Case Management) (HCA 13-884) as the second page

  ➢ The complete ICM chart, which includes the care plan

  ✓ Must be completed according to the directions on the forms

  ✓ Must be faxed to 1-866-668-1214

Telemedicine

Telemedicine is when a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered services that are within the provider's scope of practice to a client at a site other than the site where the provider is located.

ICM clients and their families may be eligible for telemedicine. Information on agency rules and how to bill for telemedicine can be found in the Physician-Related Services/Healthcare Professional Service Provider Guide.

What services are not covered under ICM?
(See WAC 182-533-0385)

The agency covers only those services that are listed in WAC 182-533-0380. Requests for noncovered services are evaluated under WAC 182-501-0160.

ICM Coverage Table

Procedure Code	Diagnosis Code	Modifier*	Short Description	Policy/ Comments
Infant Case Management				
T1017	Z76.2	HD	Targeted case management, each 15 minutes	1 unit = 15 minutes

*To receive reimbursement, tribal programs must use the procedure code and modifier above and one of these *additional* modifiers based on the client's demographic information:

Client demographic	Additional Modifier
American Indian or Alaska Native	UA
Nonnative person	SE

Billing

What are the general billing requirements?

Providers must follow the billing requirements listed in the agency's ProviderOne Billing and Resource Guide. The guide explains how to complete claims. The following table includes information specific to MSS/ICM services.

Name:	Enter:
Claim Note	The estimated due date for clients who become pregnant again before ICM ends. This is necessary in order to "reset" the clock for the new pregnancy in the claims system.
Prior Authorization	The authorization reference number for approved limitation extensions.
Place of Service	These are examples of appropriate codes for MSS/ICM. **Code** — **To Be Used For** 03 — School 05 — Indian Health Service Free-standing Facility 06 — Indian Health Service Provider-based Facility 07 — Tribal 638 Free-standing Facility 08 — Tribal 638 Provider-based Facility 11 — Office 12 — Home (Client's residence) 21 — Inpatient Hospital 22 — Outpatient Hospital 50 — Federally Qualified Health Center 72 — Rural Health Clinic 99 — Other
Service Date (From and To)	Enter one date of service per billed line. Multiple units will be billed regularly using the allowed codes.

Taxonomy code 171M00000X is appropriate for MSS/ICM Services.

See the Maternity Support Services and Infant Case Management fee schedule on the agency's Professional Rates and Billing Guides webpage.

How do I resolve issues with gender indicators when billing for transgender clients?

For a transgender client, providers must include a secondary diagnosis on the claim indicating that the client is transgender. Information on agency billing practices for transgender clients can be found in the Physician-Related Professional Services Billing Guide.